Massachusetts Department of Public Health
Confidentiality Complaint Form

Name:_____

Address:_____

Home Telephone: _____ Date of Birth:_____

Please describe the nature of the complaint including dates of occurrence. Please name the DPH program, Bureau, or any individuals involved in your complaint. Attach additional sheets if necessary.

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Your Signature or Signature of Personal Representative Date

_____
Print Name

Indicate relationship of person signing this form to the individual who is the subject of the information disclosed.
___ Person signing is the individual
___ Person signing is the Personal Representative authorized to make health care decisions for the individual. Describe the authority._____

Please mail this form to:
Privacy Office
Massachusetts Dept. of Public Health
250 Washington St.
Boston, MA 02108

NCC Form 10